

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1924

CERTIFICATE OF DEATH

Reg. Dist. No. 01917

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
c. LENGTH OF STAY IN 1b 2 Days				d. STREET ADDRESS 6 Williams St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward		First H.		Middle Barnett		Last	
4. DATE OF DEATH Feb.		Month 6,		Day 19		Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1899		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Awning Mfg.		10b. KIND OF BUSINESS OR INDUSTRY Awning Mfg.		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Barnett				14. MOTHER'S MAIDEN NAME Eva Hubbard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles E. Barnett		Address Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 4 , 19 58 , to Feb. 6 , 19 58 , that I last saw the deceased alive on Feb 6 , 19 58 , and that death occurred at 10:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE W. G. Banks M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/58		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE FEB 11 1958	
				24b. REGISTRAR'S SIGNATURE W. G. Banks			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. MARITAL STATUS</p>		<p>7. OCCUPATION</p>		<p>8. CAUSE OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. NAME OF FUNERAL HOME</p>		<p>14. NAME OF BURIAL PLACE</p>		<p>15. DATE OF BURIAL</p>		<p>16. TIME OF BURIAL</p>		<p>17. NAME OF MINISTER</p>		<p>18. NAME OF CHURCH</p>		<p>19. NAME OF CEMETERY</p>		<p>20. NAME OF INTERVIEWER</p>		<p>21. NAME OF WITNESS</p>		<p>22. NAME OF CORONER</p>		<p>23. NAME OF JURY</p>		<p>24. NAME OF JUDGE</p>	

BUREAU V. 81

FEB 11 1959

RECEIVED

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1925

CERTIFICATE OF DEATH

01918

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS 323 Washington St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First J. Middle Harry Last Brannock				4. DATE OF DEATH Month Feb. Day 24. Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/11/73	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 24. Days 19 Hours 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Neck Dist. Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Harry Brannock			
14. MOTHER'S MAIDEN NAME Mary Mowbray				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 274-07-7112				17. INFORMANT Mrs. Dolley Brannock Address 323 Washington St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Uremia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Arteriosclerotic cardio vascular renal disease DUE TO (d) 1 week DUE TO (e) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute retention due to prostatic enlargement							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- p. m. -- 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --	
20f. (City or town) -- -- --				20g. (County) -- -- --		20h. (State) -- -- --	
21. I certify that I attended the deceased from 2-13-58 , 19 58 , to 2-24-58 , 19 58 , that I last saw the deceased alive on 2-24-58 , 19 58 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 2-26-58							
ACTUAL SIGNATURE Eldridge H. Wolff				M.D. 15 Locust Street, Cambridge, Md.			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR MAR 7 '58	
						24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. RACE [REDACTED]</p>	
<p>5. DATE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF BIRTH [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR [REDACTED]</p>	
<p>13. DATE OF SIGNATURE [REDACTED]</p>		<p>14. PLACE OF SIGNATURE [REDACTED]</p>	

BURMAN & S.

MAR 7 1958

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1946

CERTIFICATE OF DEATH

Reg. Dist. 01919

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 2212.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>-</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emory</u> Middle <u>Otis</u> Last <u>Callahan</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-71</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No Skill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zadock Callahan</u>		14. MOTHER'S MAIDEN NAME <u>Amy Ann George</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unkn.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> . <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis with Heart Disease</u> . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Several yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Assoc. With Senile Brain Disease With Psychosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>491X</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 9, 1955</u> , to <u>February 17, 1958</u> , that I last saw the deceased alive on <u>February 17, 1958</u> , and that death occurred at <u>9:10A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Virkutis</u>		ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>2-17-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Simon Virkutis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial at</u>		22b. DATE THEREOF <u>3-4-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Redlands. Calif.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		SPECIAL EXAMINATIONS	
HISTORICAL DATA		PREVIOUS ILLNESS		TREATMENT		SURVIVAL		POST-MORTEM		OTHER DATA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FAMILY	
DATE		TIME		PLACE		CITY		COUNTY		STATE	

BUREAU V. R.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03226

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Wilson Cephas</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Levi Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, say or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-14-2870</u>	
17. INFORMANT <u>Beatrice Jackson</u>		Address <u>Rt. 3 Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>D.O.A.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert StClair</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

9. SIGNATURE OF EXAMINER: _____

10. DATE: _____

11. TIME: _____

12. PLACE: _____

13. COUNTY: _____

14. CITY: _____

15. STATE: _____

16. ZIP CODE: _____

17. MEDICAL HISTORY: _____

18. PHYSICAL EXAMINATION: _____

19. LABORATORY TESTS: _____

20. OTHER INFORMATION: _____

BUREAU V. S.

MAR 10 1958

RECEIVED

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1927 CERTIFICATE OF DEATH

Reg. Dist. No.

04534

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>	
c. LENGTH OF STAY IN 1b <u>80 yrs.</u>		d. STREET ADDRESS <u>414 Pine St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amealia</u> First Middle <u>Christian</u> Last		4. DATE OF DEATH <u>2</u> Month <u>14</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Young</u>		14. MOTHER'S MAIDEN NAME <u>HENNIE HUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>!</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>14 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>13 Feb</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Edwin Fossett</u> M.D.		ADDRESS (Street, city or town, state) <u>227 Pine St Cambridge Md</u> DATE SIGNED <u>19 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fossett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Dorchester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>		24a. REC'D BY REGISTRAR <u>APR 28 '58</u>	
ADDRESS <u>CAMBRIDGE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03231

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1928

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY in 1b <u>Abt. 1 wk.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>		e. STREET ADDRESS <u>51 Douglas St.</u>	
3. NAME OF DECEASED (Type or print) <u>Isiah Cornish</u>		4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Frank Cornish</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Etta Travers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Records Cambridge Md. Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		DATE SIGNED <u>2/28/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St Clair</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 1958</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE
DEPARTMENT OF HEALTH



Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED

BUREAU V. 2

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1947

CERTIFICATE OF DEATH

01920
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>4 mo. 21 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>Rt. #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>-</u> Last <u>Dickerson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 9, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>220-32-9962</u>			
17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma</u> DUE TO (c) <u>Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Sev. yrs.</u> <u> </u> <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>9-21</u> , 19 <u>57</u> , to <u>2-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>58</u> , and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>2-14-58</u> ACTUAL SIGNATURE <u>Edwin Ward</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Edwin Ward</u> Eastern Shore State Hospital, Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2/16/1958</u>		<u>14ASKIN CEM.</u>		<u>14ASKIN M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Johnson Co.</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1929 CERTIFICATE OF DEATH

Reg. Dist. No. 01921

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Woolford Last Fitzhugh		4. DATE OF DEATH Month Feb. Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Madison	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Asbury H. Woolford		14. MOTHER'S MAIDEN NAME Lavenia Tall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Ivy F. Woolford, Madison, Md.	
17. INFORMANT Ivy F. Woolford, Madison, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Chronic Glomerular Nephritis Arteriosclerotic CVD		INTERVAL BETWEEN ONSET AND DEATH 1 month 3 yrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-16 , 19 54 , to 2-23 , 19 58 , that I last saw the deceased alive on 2-23 , 19 58 , and that death occurred at 5:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Bannan M.D.		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 2-24-58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, Burial		22b. DATE THEREOF 1 Feb. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Joppa Churchyard		22d. LOCATION (City, town, or county) (State) Madison, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 28 '58 24b. REGISTRAR'S SIGNATURE Alfred	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01922

Reg. Dist. No.

1948

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. LENGTH OF STAY IN 1b <u>1yr. 1mo. 26das</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>-</u>			
3. NAME OF DECEASED (Type or print) <u>Lydia (Lyda)</u> First <u>Lydia</u> Middle <u>Hague</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 26 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William T. Hague</u>				14. MOTHER'S MAIDEN NAME <u>Annie Elisa Newcomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>45a.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>55</u> , to <u>Feb 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>58</u> , and that death occurred at <u>7:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>Feb 3 '58</u>							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.				PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMTY</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1930
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>G.</u> Middle <u>Roland</u> Last <u>Harper</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>7,</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/24/1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>7</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>7</u> Hours <u>19</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>near Vienna Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas E. Harper</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>220-20-6501</u>		17. INFORMANT <u>Mrs Roland Harper</u> Address <u>115 Cedar St. Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>58</u> , to <u>2/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Race St. Cambridge, Md.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u> _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>East New Market Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.
FEB 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1949

CERTIFICATE OF DEATH

Reg. Dist. No.

01924

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md.</u> 301-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Merrick Convalescent Home</u>		d. STREET ADDRESS <u>602 Jeffery St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Magdalena</u> Middle <u>D.</u> Last <u>Higgins</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/85</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest H. Dunsing</u>		14. MOTHER'S MAIDEN NAME <u>Mary N. Hiltz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Federick P. Dunsing</u>		Address <u>602 Jeffery St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>7 HOURS</u> <u>10 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 JUNE 1951</u> to <u>21 FEB. 1958</u> , that I last saw the deceased alive on <u>21 FEB. 1958</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter E. Gunby</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>105 CHURCH ST</u> <u>24 FEB</u>	
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY CAMBRIDGE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. LeCompte</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1950

CERTIFICATE OF DEATH

Reg. Dist. No.

01925

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> 17x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>HIGNUTT</u> Last _____		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-20</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>William Hignutt</u>		14. MOTHER'S MAIDEN NAME <u>Nora Rutin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>E.S.H. Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholera Pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polio-cerebral myelitis; Right Hemiplegia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Feb. 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 15</u> , 19 <u>58</u> , and that death occurred at <u>9:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ettore DeFilippis</u> M.D.		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hosp.</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christiefield</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler</u> ADDRESS <u>P. O. Box, Centreville, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 15 58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

RECEIVED

Items 18-21 Film 228 4-22-58 sms

1931

01926

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY **Dorchester** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Dorchester**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cambridge** c. LENGTH OF STAY IN lb **entire life**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **13 Cambridge**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **102 Church Street** d. STREET ADDRESS **102 Church Street** e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First **Susan** Middle **Lynn** Last **Hudson** 4. DATE OF DEATH Month **Feb.** Day **28** Year **1958**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Nov. 26, 1957** 9. AGE (In years last birthday) yrs. **3** IF UNDER 1 YEAR Months **2** IF UNDER 24 HRS. Hours **2** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (State or foreign country) **Easton, Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **W. Kenneth Hudson** 14. MOTHER'S MAIDEN NAME **Mary Ellen Fishell**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT Address **W. Kenneth Hudson, 102 Church St., Cambridge, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Subdural & Subarachnoid hemorrhage**
936.9 DUE TO **cause undetermined pending final autopsy report** INTERVAL BETWEEN ONSET AND DEATH **5-10 days**
Conditions, if any, which gave rise to immediate cause (b) **Presumed trauma to Rt. Mid lateral side of Skull** **5-10 days**
(c) **cause lost.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Unknown**

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not while at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **unknown** 20f. (City or town) **Unknown** (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☒.

ACTUAL SIGNATURE **Eldridge H. Wolff** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **3-2-58**
EXAMINER'S NAME (Type) **Eldridge H. Wolff, M.D.** ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **March 2, 1958** 22c. NAME OF CEMETERY OR CREMATORY **Dorchester Memorial Park** 22d. LOCATION (City, town, or county) **Cambridge, Md.** (State)

23. FUNERAL DIRECTOR'S SIGNATURE **Kenneth R. Thomas** ADDRESS **Cambridge, Md.** 24a. REC'D BY REGISTRAR **DATE MAR 7 '58** 24b. REGISTRAR'S SIGNATURE **W. Leach**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASS. AND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM		TOXICOLOGY		LABORATORY	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF JURY		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF CORONER		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF JUDGE		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF CLERK		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF SHERIFF		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF DEPUTY SHERIFF		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF CONSTABLE		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF JURY		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF CORONER		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF JUDGE		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF CLERK		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF SHERIFF		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF DEPUTY SHERIFF		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF CONSTABLE		DATE		PLACE		CITY		STATE		COUNTY	

RECEIVED
 MAR 7 1958
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1932

CERTIFICATE OF DEATH

Reg. Dist. No. 01927

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			c. LENGTH OF STAY IN 1b 6 Mos.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenburn Convalescent Home				d. STREET ADDRESS Glenburn Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Mary First Hubbard Middle Hurley Last				4. DATE OF DEATH Feb. Month 9, Day 19 58 Year									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/1874		9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Casons Neck Dorchester Co.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Hubbard						14. MOTHER'S MAIDEN NAME Anna Cook							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Irving Hurley				Address Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 4 hours </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Scurvy													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Feb 8 , 19 58 , to Feb 9 , 19 58 , that I last saw the deceased alive on Feb 8 , 19 58 , and that death occurred at 9 P. M, from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> ADDRESS (Street, city or town, state) DATE SIGNED </div>													
ACTUAL SIGNATURE [Signature] M.D.													
PHYSICIAN'S NAME (Type)													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/12/58		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park				22d. LOCATION (City, town, or county) (State) Cambridge Md.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service						ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR FEB 14 '58		24b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1951

CERTIFICATE OF DEATH

Reg. Dist. No.

01928

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2yr 9mo 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lynn</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Jones</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Craft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>RECORDS: Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Paralysis - right side</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Sev. yrs.</u> <u>11 11</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5-9</u> , 19 <u>55</u> , to <u>2-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>58</u> , and that death occurred at <u>12:15A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Simon Virkutis</u>				ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital, Cambridge, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Simon Virkutis</u>				DATE SIGNED <u>2-13-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Firemans</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Marvel-Sharptown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Ch. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be forwarded for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1933

CERTIFICATE OF DEATH

Reg. Dist. No. 01929

1. PLACE OF DEATH a. COUNTY <u>Dor</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Leeds Grove, Md</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Charles Kelley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/881</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jessie H. Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Ernie Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Harry Kelley - Leeds Grove</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 15</u> , 19 <u>58</u> , to <u>Feb. 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>58</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert E. Barker</u> M.D.		ADDRESS (Street, city or town, state) <u>200 Maryland Ave.</u> DATE SIGNED <u>2/19/58</u>	
PHYSICIAN'S NAME (Type) <u>Albert E. Barker M.D. Cambridge - Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Halloway, O. N. Martel</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Overman</u>

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7 MAR 1958

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1934

CERTIFICATE OF DEATH

01930

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 50 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. STREET ADDRESS 103 Choptank Ave.	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Harrison Last Langrall		4. DATE OF DEATH Month Feb. Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 19 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman self employed		10b. KIND OF BUSINESS OR INDUSTRY Bishops Head, Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm. Henry Langrall		14. MOTHER'S MAIDEN NAME Rachael Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Eugie F. Langrall, 103 Choptank Ave., Camb., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Metastasis DUE TO (c) Carcinoma Prostate		INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 month 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-2-54 to 2-12-58 , that I lost saw the deceased olive on 2-12-58 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. B. Bannerman		DATE SIGNED 2-14-58	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shivers		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE FEB 19 '58		24b. REGISTRAR'S SIGNATURE Reg. Dist. No.	

CERTIFICATE OF DEATH

RECEIVED
FEB 19 1959
BUREAU V. S.

1935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester CO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Freddie Middle William Last Murphy				4. DATE OF DEATH Month Feb. Day 1, Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/57		9. AGE (In years last birthday) yrs. 7 Months 9 Days 9 Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William H. Murphy				14. MOTHER'S MAIDEN NAME Florence I. Doege			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT William H. Murphy Address Cambridge RFD # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Labar Pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 3 days INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 12-9-58 to 4-1-58 , that I last saw the deceased alive on 12-58 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust ST. Cambridge Md. DATE SIGNED 4/3/58							
ACTUAL SIGNATURE W. H. Hanks M.D.				PHYSICIAN'S NAME (Type) W. H. Hanks			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/58		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeOompte Funeral Service				ADDRESS Ca mbridge Md.		24a. REC'D BY REGISTRAR DATE FEB 6 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Hanks			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2067222xv6

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1923		5. PLACE OF BIRTH Jackson, Mississippi		6. RACE White		7. MARRIAGE Married		8. OCCUPATION Attorney		9. CAUSE OF DEATH Suicide		10. MANNER OF DEATH Homicide		11. PLACE OF DEATH Baltimore, Maryland		12. DATE OF DEATH April 4, 1968		13. TIME OF DEATH 2:01 PM		14. SIGNATURE OF DECEASED James Earl Ray		15. SIGNATURE OF WITNESS John Edgar Hoover		16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF JURY J. Edgar Hoover		19. SIGNATURE OF JUDGE J. Edgar Hoover		20. SIGNATURE OF CLERK J. Edgar Hoover		21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF ARCHIVIST J. Edgar Hoover		23. SIGNATURE OF LIBRARIAN J. Edgar Hoover		24. SIGNATURE OF CURATOR J. Edgar Hoover		25. SIGNATURE OF HISTORIAN J. Edgar Hoover		26. SIGNATURE OF PRESIDENT J. Edgar Hoover		27. SIGNATURE OF VICE PRESIDENT J. Edgar Hoover		28. SIGNATURE OF SENATE J. Edgar Hoover		29. SIGNATURE OF HOUSE OF REPRESENTATIVES J. Edgar Hoover		30. SIGNATURE OF SUPREME COURT J. Edgar Hoover		31. SIGNATURE OF DISTRICT COURT J. Edgar Hoover		32. SIGNATURE OF COUNTY COURT J. Edgar Hoover		33. SIGNATURE OF JUDICIAL CIRCUIT J. Edgar Hoover		34. SIGNATURE OF APPELLATE COURT J. Edgar Hoover		35. SIGNATURE OF SUPREME COURT J. Edgar Hoover		36. SIGNATURE OF DEPARTMENT OF HEALTH J. Edgar Hoover		37. SIGNATURE OF DEPARTMENT OF JUSTICE J. Edgar Hoover		38. SIGNATURE OF DEPARTMENT OF AGRICULTURE J. Edgar Hoover		39. SIGNATURE OF DEPARTMENT OF COMMERCE J. Edgar Hoover		40. SIGNATURE OF DEPARTMENT OF EDUCATION J. Edgar Hoover		41. SIGNATURE OF DEPARTMENT OF ENERGY J. Edgar Hoover		42. SIGNATURE OF DEPARTMENT OF ENVIRONMENTAL PROTECTION J. Edgar Hoover		43. SIGNATURE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES J. Edgar Hoover		44. SIGNATURE OF DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT J. Edgar Hoover		45. SIGNATURE OF DEPARTMENT OF INTERIOR J. Edgar Hoover		46. SIGNATURE OF DEPARTMENT OF LABOR J. Edgar Hoover		47. SIGNATURE OF DEPARTMENT OF TRANSPORTATION J. Edgar Hoover		48. SIGNATURE OF DEPARTMENT OF DEFENSE J. Edgar Hoover		49. SIGNATURE OF DEPARTMENT OF STATE J. Edgar Hoover		50. SIGNATURE OF DEPARTMENT OF THE ARMY J. Edgar Hoover		51. SIGNATURE OF DEPARTMENT OF THE NAVY J. Edgar Hoover		52. SIGNATURE OF DEPARTMENT OF THE AIR FORCE J. Edgar Hoover		53. SIGNATURE OF DEPARTMENT OF THE MARINE CORPS J. Edgar Hoover		54. SIGNATURE OF DEPARTMENT OF THE COAST GUARD J. Edgar Hoover		55. SIGNATURE OF DEPARTMENT OF THE NATIONAL GUARD J. Edgar Hoover		56. SIGNATURE OF DEPARTMENT OF THE NATIONAL RESERVE J. Edgar Hoover		57. SIGNATURE OF DEPARTMENT OF THE NATIONAL MILITARY RESERVE J. Edgar Hoover		58. SIGNATURE OF DEPARTMENT OF THE NATIONAL AIR RESERVE J. Edgar Hoover		59. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		60. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		61. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		62. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		63. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		64. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		65. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		66. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		67. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		68. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		69. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		70. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		71. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		72. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		73. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		74. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		75. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		76. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		77. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		78. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		79. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		80. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		81. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		82. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		83. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		84. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		85. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		86. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		87. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		88. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		89. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		90. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		91. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		92. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		93. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		94. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		95. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		96. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		97. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		98. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover		99. SIGNATURE OF DEPARTMENT OF THE NATIONAL COAST GUARD RESERVE J. Edgar Hoover		100. SIGNATURE OF DEPARTMENT OF THE NATIONAL MARINE CORPS RESERVE J. Edgar Hoover	
---------------------------------------	--	----------------	--	--------------	--	----------------------------------	--	---	--	------------------	--	------------------------	--	---------------------------	--	------------------------------	--	---------------------------------	--	---	--	------------------------------------	--	------------------------------	--	---	--	---	--	---	--	---	--	--	--	---	--	---	--	---	--	---	--	---	--	---	--	---	--	---	--	--	--	--	--	--	--	---	--	--	--	--	--	--	--	---	--	---	--	--	--	---	--	---	--	--	--	---	--	--	--	--	--	---	--	---	--	--	--	---	--	--	--	---	--	---	--	--	--	--	--	---	--	--	--	---	--	--	--	--	--	---	--	--	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	--	--

BUREAU V. 4

FEB 6 1968

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 6 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glasgow Convalescing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nora Middle Newberry Last Neild		4. DATE OF DEATH Month Feb. Day 25 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/70
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 8 Days 25 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Woolford Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Demetrius Neild Newberry		14. MOTHER'S MAIDEN NAME Henrietta Linthicum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hugh Neild		Address Washington D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck right femur.			INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell while getting out of bed.	
20c. TIME OF INJURY Month, Day, Year Hour 5:30 a. m. 2/18 p. m. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) (County) (State) Cambridge, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 3/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58	
22c. NAME OF CEMETERY OR CREMATORY Old Trinity Church		22d. LOCATION (City, town, or county) (State) Church Creek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 3/1/58	

MEDICAL CERTIFICATION

09

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAR 7 1933

RECEIVED

1952

CERTIFICATE OF DEATH

01933

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hoopersville Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hoopersville Md.</u>				d. STREET ADDRESS <u>Hoopersville Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Parks</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/1877</u>		9. AGE (In years last birthday) yrs. <u>80</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood Packer</u>		11. BIRTHPLACE (State or foreign country) <u>Hoopersville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Parks</u>				14. MOTHER'S MAIDEN NAME <u>Mary White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Charles Parks</u>		Address <u>Hoopersville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CVD</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>58</u> , to <u>2-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>58</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Bannerman</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Cambridge Md. 2-14-58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ab. LeCompte</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 19 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1937

CERTIFICATE OF DEATH

01934

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lilly Middle Creighton Last Phillips				4. DATE OF DEATH Month Feb. Day 2, Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/1884	
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fishing Creek Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edward Creighton				14. MOTHER'S MAIDEN NAME Sarah Creighton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Charles W. Phillips Address Fishing Creek Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive CVD DUE TO (c) 1 month INTERVAL BETWEEN ONSET AND DEATH 10. min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-16 , 19 58 , to 2-2 , 19 58 , that I last saw the deceased alive on 2-2 , 19 58 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 2-7-58 ACTUAL SIGNATURE W. Bannan M.D. PHYSICIAN'S NAME (Type) W. Bannan							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/58		22c. NAME OF CEMETERY OR CREMATORY Hoosier Church		22d. LOCATION (City, town, or county) (State) Fishing Creek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR FEB 6 58 24b. REGISTRAR'S SIGNATURE W. Bannan	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. M.

6 FEB 1958



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1938

CERTIFICATE OF DEATH

Reg. Dist. No. 01935

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Talbot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>9 da.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> <u>20x. 2</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>Winters</u> Middle <u>Rakes</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/23/91</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Phildman Rakes</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Leatherberry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, list, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>214-07-1444</u>	
17. INFORMANT <u>Miss Patricia Rakes</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis, acute, recurrent</u> DUE TO (c) <u>Arterio-sclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>5 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Obesity, simple (2) Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb-13</u> , 19 <u>58</u> , to <u>Feb-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb-17</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Thompson</u>		ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u>	
DATE SIGNED <u>Feb-20, '58</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cem.</u>
22d. LOCATION (City, town, or county) <u>Trappe</u>		(State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Shull, Eastern, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Outreach</u>			

FEB 26 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1953

CERTIFICATE OF DEATH

01936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>6 1/2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Eastern Shore State Hosp-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>TVA-</u> Middle <u>MAY</u> Last <u>Roach-</u>				4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.H.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.H.</u>							
13. FATHER'S NAME <u>Charles Simpson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann - Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Relatives Ocean City, Md. - Sister</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO <u>Fibrosis Left Lung (massive)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arterio Sclerosis Ob. Brain Syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>5-30</u> , 19 <u>57</u> , to <u>2-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>58</u> , and that death occurred at <u>1230 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin J. Ward</u> M.D.				ADDRESS (Street, city or town, state)			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>EDWIN J. WARD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annmarie Busborge</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Ward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1954

Reg. Dist. No. 01937

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Federalsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D.#2</u>				d. STREET ADDRESS <u>R.F.D.#2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Roy</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/6/1900</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cinder block</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mottish Roy</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Ann Earl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-7510</u>		17. INFORMANT Address <u>Mr. Lillian Handy Federalsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				DATE SIGNED <u>2/14/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hamondtown</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rawlings Funeral Home</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 18 58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Ch. E. Enoch</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

BUREAU V. 1

FEB 18 1958

RECEIVED

1939 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
c. LENGTH OF STAY IN 1b 2 Weeks		d. STREET ADDRESS 4 Light St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle G. Last Shorter		4. DATE OF DEATH Month Feb. Day 23, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-71
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Police Officer	11. BIRTHPLACE (State or foreign country) Lakesville Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Shorter Jr. Address Wilmington Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic cardio vascular renal disease DUE TO (c) Arterio sclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 1 hour unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate with metastasis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m. -- --		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --
20f. (City or town) -- -- --		(County) (State)	
21. I certify that I attended the deceased from 1-18-58 , 19__, to 2-23-58 , 19__, that I last saw the deceased alive on 2-23-58 , 19__, and that death occurred at 7:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. 2-25-58			
ACTUAL SIGNATURE Eldridge H. Wolff			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/58	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24. REC'D BY REGISTRAR DATE MAR 7 '58	
ADDRESS Cambridge Md.		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF FUNERAL HOME [Faint text]	
NAME OF NEXT OF KIN [Faint text]		NAME OF MINISTER [Faint text]	
NAME OF BURIAL PLACE [Faint text]		NAME OF CEMETERY [Faint text]	
NAME OF CITY [Faint text]		NAME OF COUNTY [Faint text]	
NAME OF STATE [Faint text]		NAME OF COUNTRY [Faint text]	

BUREAU V. S.

MAR 7 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01939

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenburn Convalescent Home		d. STREET ADDRESS Church Creek Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Etta Hughes Simmons		4. DATE OF DEATH Month Feb. Day 23, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/79
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Golden Hill Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Hughes		14. MOTHER'S MAIDEN NAME Martha Todd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT Carl Simmons Address Neck Dist. Dorchester Co.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 11-15 , 19 57 , to 2/23 , 19 58 , that I last saw the deceased alive on 2/23 , 19 58 , and that death occurred at 3:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred R. Maryanov M.D. 136 Race St		DATE SIGNED 2/24/58	
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		Cambridge,	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/26/58	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DATE MAR 7 '58	
ADDRESS Cambridge Md.		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1941

CERTIFICATE OF DEATH

Reg. Dist. No.

01940

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. LENGTH OF STAY IN 1b 8 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ca mbridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Clarence Middle Slacum Last Slacum				4. DATE OF DEATH Month Feb. Day 7, Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY A. P. Stores Co.			
11. BIRTHPLACE (State or foreign country) Taylors Island Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles E. Slacum				14. MOTHER'S MAIDEN NAME Annie Navy Slacum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Clarence Slacum				Address 113 Choptank Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Source Bladder DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/15 19 52 , to 7-7 19 58 , that I last saw the deceased alive on 24 7, 19 58 , and that death occurred at 10:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE W. J. Slacum M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/58		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lecompte Funeral Service				ADDRESS Cambridge Md.			
24a. REC'D BY REGISTRAR DATE FEB 11 '58				24b. REGISTRAR'S SIGNATURE W. J. Slacum			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 10

RECEIVED
FEB 11 1953
BUREAU V. S.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the coroner. TO CHIEF MEDICAL EXAMINER'S Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01941

1942

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital				d. STREET ADDRESS 109 Muse St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lula Maud Smith				4. DATE OF DEATH Month Day Year Feb. 13, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/88	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Vienna Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W. McNamara				14. MOTHER'S MAIDEN NAME Amie Christopher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-7606		17. INFORMANT Norman Smith Address Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 904.0 (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture dislocation left ankle.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 5:00 P.M. Jan. 12, 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cambridge, Dorchester, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. John Mace Jr.				DATE SIGNED 2/15/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/58		22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE FEB 19 58	
						24b. REGISTRAR'S SIGNATURE Alfred Smith	

MAINE AND STATE DEPARTMENT OF HEALTH-BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be submitted to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> 1955 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secetary</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mattie Merrick Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Reids Grove</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>N.</u> Middle <u>Stokes</u> Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		4. DATE OF DEATH <u>February</u> Month <u>10</u> Day <u>1958</u> Year 9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>John Stokes</u> 14. MOTHER'S MAIDEN NAME <u>Amelia</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>1</u> 17. INFORMANT <u>Mrs. Mattie Merrick</u> Address <u>Secetary, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>420.1</u> DUE TO cave lost. (c) <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1</u> 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/14/58</u> DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2/14/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Reids Grove</u> 22d. LOCATION (City, town, or county) (State) <u>Reids Grove, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willoughby Funeral Directors East New Market</u> ADDRESS <u>1</u>		24a. REC'D BY REGISTRAR <u>FEB 18 58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

BUREAU V. 1

FEB 18 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1956 CERTIFICATE OF DEATH

01943

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Federalburg</u>			
3. NAME OF DECEASED (Type or print) First <u>TILGHMAN</u> Middle <u>COLUMBUS</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/6/76</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Tilghman Thomas</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Bowdle</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		
20f. (City or town) (County) (State) <u>_____</u>							
21. I certify that I attended the deceased from <u>Dec. 17</u> , 19 <u>57</u> , to <u>Feb. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 26</u> , 19 <u>58</u> , and that death occurred at <u>3:40p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> <u>2/26/58</u> PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federalburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Wellesley - Federalburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>_____</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01944

Reg. Dist. No.

1943

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 437 Pine St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Md. d. STREET ADDRESS 437 Pine St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alverda Middle Josephine Last Thompson		4. DATE OF DEATH Month February Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 16 Hours 19 Min. 58	IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food packing	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME John Thompson	
14. MOTHER'S MAIDEN NAME Annie Cornish		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 218-05-9076		17. INFORMANT Inez Farrow Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/58	22c. NAME OF CEMETERY OR CREMATORY Taylor's Island Cemetery	22d. LOCATION (City, town, or county) (State) Taylor's Island Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR MAR 10 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TWO FOR ONE CERTIFICATE - Film G226 - 3/13/58

BUREAU V. S.

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1944 CERTIFICATE OF DEATH

Reg. Dist. No.

01945

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
c. LENGTH OF STAY IN b. 15 yrs.				d. STREET ADDRESS 5 Park Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Park Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Oliver Last Thompson				4. DATE OF DEATH Month Feb. Day 19 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 8 Days 10 Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thompson				14. MOTHER'S MAIDEN NAME Clara Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 157-01-6796		17. INFORMANT Mrs Elizabeth Thompson, Cambridge, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza DUE TO 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus (b) arterio sclerosis (c) retinosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1957 to Feb 1958 , that I last saw the deceased alive on Feb 19 1958 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 							
ACTUAL SIGNATURE J. A. Thompson M.D.				PHYSICIAN'S NAME (Type) J. A. Thompson Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 2/22/1958		22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR MAR 6 '58		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

Reg. Dist. No. 01946

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toddville, Md.</u>		c. LENGTH OF STAY IN life <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toddville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Toddville, Md.</u>			d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lola</u> Middle <u>Jones</u> Last <u>Todd</u>			4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1874</u>		9. AGE (In years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Toddville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Caleb Jones</u>			14. MOTHER'S MAIDEN NAME <u>Georgiana Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Ottie Todd</u> Address <u>Toddville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(County) (State)</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>2/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	
				22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>			24a. REC'D BY REGISTRAR <u>FEB 6 58</u>		
ADDRESS <u>Cambridge, Md.</u>			24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

BUREAU V. 3

FEB 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1958 CERTIFICATE OF DEATH

01947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Moses Middle Columbus Last Wilson				4. DATE OF DEATH Month Feb. Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 31, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wilson				14. MOTHER'S MAIDEN NAME Anne Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Irene Wilson, Smithville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral blood failure DUE TO arterio-sclerotic CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic CVD DUE TO arterio-sclerotic CVD (c) arterio-sclerotic CVD							INTERVAL BETWEEN ONSET AND DEATH 1 mo ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20 , 1957, to Feb 2 , 1958, that I last saw the deceased alive on Feb 1 , 1958, and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Herbert M. Sellman M.D. Cambridge, Md. Feb 5, 58 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/1958		22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery		22d. LOCATION (City, town, or county) (State) Smithville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Sellman				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 7 '58	
				24b. REGISTRAR'S SIGNATURE W. Beach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

See Back for Instructions

1. PLACE OF DEATH Home		2. DATE OF DEATH Jan 15 1952	
3. COUNTY OF DEATH Baltimore		4. CITY OF DEATH Baltimore	
5. NAME OF DECEASED William Wilson		6. SEX Male	
7. AGE 65		8. RACE White	
9. MARITAL STATUS Married		10. OCCUPATION Retired	
11. BIRTH DATE Oct 17 1886		12. BIRTH PLACE Baltimore	
13. DECEASED'S RESIDENCE 1000 North Avenue		14. DECEASED'S OCCUPATION Retired	
15. DECEASED'S RELIGION Roman Catholic		16. DECEASED'S EDUCATION High School	
17. DECEASED'S MARRIAGE Married		18. DECEASED'S PREVIOUS MARRIAGES None	
19. DECEASED'S PREVIOUS MARRIAGES None		20. DECEASED'S PREVIOUS MARRIAGES None	
21. DECEASED'S PREVIOUS MARRIAGES None		22. DECEASED'S PREVIOUS MARRIAGES None	
23. DECEASED'S PREVIOUS MARRIAGES None		24. DECEASED'S PREVIOUS MARRIAGES None	
25. DECEASED'S PREVIOUS MARRIAGES None		26. DECEASED'S PREVIOUS MARRIAGES None	
27. DECEASED'S PREVIOUS MARRIAGES None		28. DECEASED'S PREVIOUS MARRIAGES None	
29. DECEASED'S PREVIOUS MARRIAGES None		30. DECEASED'S PREVIOUS MARRIAGES None	
31. DECEASED'S PREVIOUS MARRIAGES None		32. DECEASED'S PREVIOUS MARRIAGES None	
33. DECEASED'S PREVIOUS MARRIAGES None		34. DECEASED'S PREVIOUS MARRIAGES None	
35. DECEASED'S PREVIOUS MARRIAGES None		36. DECEASED'S PREVIOUS MARRIAGES None	
37. DECEASED'S PREVIOUS MARRIAGES None		38. DECEASED'S PREVIOUS MARRIAGES None	
39. DECEASED'S PREVIOUS MARRIAGES None		40. DECEASED'S PREVIOUS MARRIAGES None	
41. DECEASED'S PREVIOUS MARRIAGES None		42. DECEASED'S PREVIOUS MARRIAGES None	
43. DECEASED'S PREVIOUS MARRIAGES None		44. DECEASED'S PREVIOUS MARRIAGES None	
45. DECEASED'S PREVIOUS MARRIAGES None		46. DECEASED'S PREVIOUS MARRIAGES None	
47. DECEASED'S PREVIOUS MARRIAGES None		48. DECEASED'S PREVIOUS MARRIAGES None	
49. DECEASED'S PREVIOUS MARRIAGES None		50. DECEASED'S PREVIOUS MARRIAGES None	
51. DECEASED'S PREVIOUS MARRIAGES None		52. DECEASED'S PREVIOUS MARRIAGES None	
53. DECEASED'S PREVIOUS MARRIAGES None		54. DECEASED'S PREVIOUS MARRIAGES None	
55. DECEASED'S PREVIOUS MARRIAGES None		56. DECEASED'S PREVIOUS MARRIAGES None	
57. DECEASED'S PREVIOUS MARRIAGES None		58. DECEASED'S PREVIOUS MARRIAGES None	
59. DECEASED'S PREVIOUS MARRIAGES None		60. DECEASED'S PREVIOUS MARRIAGES None	
61. DECEASED'S PREVIOUS MARRIAGES None		62. DECEASED'S PREVIOUS MARRIAGES None	
63. DECEASED'S PREVIOUS MARRIAGES None		64. DECEASED'S PREVIOUS MARRIAGES None	
65. DECEASED'S PREVIOUS MARRIAGES None		66. DECEASED'S PREVIOUS MARRIAGES None	
67. DECEASED'S PREVIOUS MARRIAGES None		68. DECEASED'S PREVIOUS MARRIAGES None	
69. DECEASED'S PREVIOUS MARRIAGES None		70. DECEASED'S PREVIOUS MARRIAGES None	
71. DECEASED'S PREVIOUS MARRIAGES None		72. DECEASED'S PREVIOUS MARRIAGES None	
73. DECEASED'S PREVIOUS MARRIAGES None		74. DECEASED'S PREVIOUS MARRIAGES None	
75. DECEASED'S PREVIOUS MARRIAGES None		76. DECEASED'S PREVIOUS MARRIAGES None	
77. DECEASED'S PREVIOUS MARRIAGES None		78. DECEASED'S PREVIOUS MARRIAGES None	
79. DECEASED'S PREVIOUS MARRIAGES None		80. DECEASED'S PREVIOUS MARRIAGES None	
81. DECEASED'S PREVIOUS MARRIAGES None		82. DECEASED'S PREVIOUS MARRIAGES None	
83. DECEASED'S PREVIOUS MARRIAGES None		84. DECEASED'S PREVIOUS MARRIAGES None	
85. DECEASED'S PREVIOUS MARRIAGES None		86. DECEASED'S PREVIOUS MARRIAGES None	
87. DECEASED'S PREVIOUS MARRIAGES None		88. DECEASED'S PREVIOUS MARRIAGES None	
89. DECEASED'S PREVIOUS MARRIAGES None		90. DECEASED'S PREVIOUS MARRIAGES None	
91. DECEASED'S PREVIOUS MARRIAGES None		92. DECEASED'S PREVIOUS MARRIAGES None	
93. DECEASED'S PREVIOUS MARRIAGES None		94. DECEASED'S PREVIOUS MARRIAGES None	
95. DECEASED'S PREVIOUS MARRIAGES None		96. DECEASED'S PREVIOUS MARRIAGES None	
97. DECEASED'S PREVIOUS MARRIAGES None		98. DECEASED'S PREVIOUS MARRIAGES None	
99. DECEASED'S PREVIOUS MARRIAGES None		100. DECEASED'S PREVIOUS MARRIAGES None	

RECEIVED
FEB 7 1952
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03275

Reg. Dist. No.

1945

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>60 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>425 Pine St.</u>			d. STREET ADDRESS <u>425 Pine St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Young</u> Last <u>Young</u>			4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>Unknown</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Junk Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Junk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Young</u>		
14. MOTHER'S MAIDEN NAME <u>Henritta Hunt</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Carol Young</u> Address <u>Cambridge, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Cambridge</u>	(County) <u>Dorchester</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dr. John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/6/58</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oldfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Dorchester Co. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate may be executed at any time within 72 hours after death. If any delay is necessary, the certificate may be executed at any time within 72 hours after death. If any delay is necessary, the certificate may be executed at any time within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1912

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

SKIN

EYES

EARS

NOSE

MOUTH

THROAT

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

TESTES

PROSTATE

SEMINAL VESICLE

URETER

URETHRA

BLADDER NECK

URETERAL ORIFICE

URETERAL CATHETER

URETERAL CATHETER

URETERAL CATHETER

URETERAL CATHETER

URETERAL CATHETER

URETERAL CATHETER

URETERAL CATHETER

BUREAU V. E.

APR 7 1958

RECEIVED